The inclusion of the words ''facilitate'' and ''possible'' underscores that no specific exchange is required and that any exchange which does occur is limited to that which we determine would be appropriate and permitted under the Convention.

I think it is clear from this analysis that our own Department of Defense feels very comfortable with the provisions of this Chemical Weapons Convention. The overriding context that this convention is presented to us in has to be considered, Mr. President, whenever you are debating the chemical weapons treaty or the Chemical Weapons Convention.

Sometime over a decade ago, the United States made a decision to terminate the use of chemical weapons and, in fact, to destroy our stockpile of chemical weapons. President Reagan signed the law to do just that. In accordance with that, President Bush came along, after President Reagan, and went ahead and carried out that policy and entered into the Chemical Weapons Convention on behalf of the country and sent the treaty to the Senate for consideration. It has been languishing here ever since President Bush sent it here for consideration.

I think that we would have a very different debate and you would have a very different lineup of people on different sides of this issue—and, frankly, you would have many more people in opposition to this treaty—if, in fact, we had not made a decision and put in our own law a provision to renounce the use of chemical weapons. But we did. We made that decision. President Reagan signed that law.

And now for people to come to the floor and say, no, no, we are going to be putting ourselves at some kind of disadvantage if we enter into a treaty with 161 other countries which would subject them to the same kind of policy decision which we already made some decade ago, just has no logic to it.

Clearly, there are problems in verifying this treaty. There are problems in verifying any treaty. They are probably complicated when it comes to verifying a treaty to ban chemical weapons because it takes such a small amount of technology and such a small amount of space to produce chemical weapons. But that does not mean that we should just give up on any and all efforts to verify and any and all efforts to inspect.

I think Madeleine Albright, our Secretary of State, made the point very well in a statement she made yesterday where she said, just because there may be people—and there are people—who will continue to murder and pillage and sell drugs, does not mean we should not pass laws to prohibit that. We should pass those laws. We should do our very best to enforce those laws and implement them. That is true with chemical weapons as well.

There may be people—and there undoubtedly will be—some rogue states and some individual groups, terrorist groups, that try to violate this treaty. All I can say is, we need to redouble our efforts to enforce the treaty once we ratify it. We need to work with other countries to gain their assistance in doing that enforcement.

Clearly, it is in the best interest of the people of this country that we take every action we possibly can to reduce the likelihood that chemical weapons will ever be used against Americans in future conflicts or in a nonconflict situation. Perhaps the biggest threat that we face is not in the use of chemical weapons in a conflict. The biggest threat may be the kind of an incident that occurred in Japan in a subway where a terrorist group decides that for some perverted reason they are going to engage in the use of chemical weapons. This treaty will help us to ferret out those kinds of incidents, those kinds of risks and to deal with them ahead of time. I think it is clearly in our best interest to do so.

Mr. President, let me just say that I have confidence that the Senate, if allowed to vote on this issue, will vote by the necessary supermajority to go ahead and pass the treaty and ratify the treaty. What we are up against now is an inability to get the treaty to the floor for a vote. And that, I think, is a very sad procedural circumstance that we have. We have a committee chair who has announced that he may or may not allow this issue to be reported from the committee so that the full Senate can express its will on the subject.

Mr. President, I hope very much that my colleagues will join me in seeing to it that we do get this issue to the floor, and that we go ahead and vote on the treaty. If a Senator wants to vote against the Chemical Weapons Convention and go home and explain to his or her constituents why they voted against the Chemical Weapons Convention, then fine. That is the way the system is supposed to work.

But for us to deny Members the right to vote is really indefensible, in my view, on an issue of this importance. This is tremendously important. I have urged, as several Members know, the Democratic leader, and indicated to the majority leader that I thought it was irresponsible for the Senate to continue doing business as usual while this issue continues to languish in committee.

The deadline is approaching. This is time sensitive. We need to go ahead and get the issue to the floor and allow a good debate, allow amendments, and allow a vote on the Chemical Weapons Convention.

I think that needs to be our top priority this April. And we are still early enough in the month that we can bring this to the floor, debate it, vote on it, and let the Senate do its will. The American people have a right to expect that from us. And clearly we need to go ahead and follow that course of action.

I think for us to continue with discussions about: Well, it does not really matter whether we sign up now or sign up in June or maybe July or maybe this fall some time, that is not accurate, Mr. President. It does matter. And we will be giving up a leadership role that we should have on arms control issues. We will be giving up a leadership role we should have on the banning of chemical weapons. Clearly, I think that is contrary to the best interests of the people I represent and contrary to the best interests of the American people generally.

Mr. President, I urge the majority leader and my colleagues on both sides of the aisle to put aside other business, and bring this issue to the floor. Let us vote on it. Let us have a debate. Anyone who wants to offer an amendment should be able to do that. Anyone who wants to offer implementing legislation should be able to do that. The Senate should vote on it, and then get about other business. So I hope that is the course we follow.

Mr. President, I know there will be additional chances this afternoon and later on to debate this issue in more depth. I look forward to those. I believe very firmly that this is one of the most important issues this Congress, this 105th Congress, will address. I hope very much that we will clear the other procedural matters and the other substantive matters that are on the agenda and get on to a vote on the Chemical Weapons Convention.

Mr. President, with that I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. ASHCROFT). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. WYDEN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

MEDICARE REFORM

Mr. WYDEN. Mr. President, as I indicated yesterday, I intend to come to the Senate floor each day this week as part of an effort to build bipartisan support in the Senate for Medicare reform. It is very clear to me that there is a rare window of opportunity now for the Senate to act on this issue, a window, an opportunity I think would be a serious mistake to not exploit.

We know that the Federal deficit is a bit lower than was anticipated this year, in the vicinity of $108 billion. We are seeing that there is a fairly benign economic environment. Certainly, there are still folks hurting in our country, but, overall, the economy has been positive. We know that we are a few years away from what I believe is sure to be a demographic earthquake, with many more older people in our country, and older people who need and deserve good quality health care.

Yesterday, I tried to outline what I thought were the central principles of comprehensive Medicare reform. Beginning today, Mr. President, I intend to

try to outline some of the specific aspects of what Medicare reform ought to consist of and how to get this program on track for the 21st century so that it operates in a fashion that is good for both older people and for taxpayers.

Right now, in much of the United States, the Medicare Program is a 30-year-old, ''Tin Lizzy''-style operation that rewards waste and penalizes frugality. This is particularly unfortunate since the end result is that in communities like my own in Portland, OR, that hold down costs, the end result for all the heavy lifting is simply a smaller reimbursement check. I believe what we have today under the Medicare Program is a situation where because of the reimbursement of formula, a sleep-inducing, eye-glazing concept known as the average adjusted per capita cost, you have a situation where in much of the United States there are few, if any, choices for older people under Medicare because health plans are reluctant to come to those markets, or you have a situation where it is almost impossible for an older person to navigate the system simply because they cannot obtain understandable, coherent information about their Medicare choices.

Mr. President, it would be impossible for you to be able to see this chart, but I intend in the days ahead to blow this up because it makes my point with respect to how Medicare has made it difficult to have true competition like the competition that exists in the private sector for health care. This chart, which obviously is going to be difficult for you, Mr. President, and those who may be watching to see, involves a wall that has been set up in Los Angeles with all of the information that an older person has to go through in Los Angeles to make choices about choosing a health plan. It clearly illustrates, in my view, what we have seen with the Medicare Program over the last few years.

Because the reimbursement formula encourages waste and penalizes frugality, we will have, in many areas, few choices for Medicare, discouraging competition, or, as I have shown through this chart and picture developed by the General Accounting Office, you will have just a blizzard of information that older people find it very difficult to navigate and make sense out of, thereby making it hard for them to have real choice in their health system.

The irony, of course, is that every Member of the U.S. Senate knows what a competitive health system could look like, and a competitive health system that avoids the kind of problems I have just demonstrated with this chart from the General Accounting Office. Mr. President, 21st century Medicare could really be modeled around the very program that Members of the U.S. Senate participate in, known as the Federal employee health benefits plan. The Federal employee health benefits plan offers enrollees a portfolio of plans, each one with somewhat different service offerings. Consumers are helped to make appropriate, independent choices because the managers of the Federal employee plan pay attention to the details, including the way plans develop written explanations presenting what individual policies will or will not do.

So for Members of the U.S. Senate, it is possible to get understandable, coherent information about what is available for Senators and their families. But if you are an older person who wants to compare and shop for health care, you have to try to figure out how to make sense of this incomprehensible picture that I just showed, demonstrated by the General Accounting Office.

In addition, in the Federal employee health system, policies are inspected and reviewed on performance, and Federal employee plan participants are then given what amounts to report card grades on many of the important care provisions so that average consumers can sit down at their kitchen table and make plan-against-plan comparisons when they choose their coverage.

Again, the difference between what is available to older people in many parts of the United States for Medicare and what is available to those Federal employees and Members of the U.S. Senate is striking in its contrast. Members of the Senate and Federal employees are going to be in a position where they can make plan-against-plan comparisons so as to inject some competition in the system. Again, the General Accounting Office tells us that no such features exist in much of Medicare.

Finally, the Federal employee benefits managers look for high-quality service at competitive rates for employees. They work on a competitive basis to upgrade the quality and prices for the plan, while keeping premium rates at the lowest possible level. At the same time, these managers work to diminish risk selection by the plans, so that the older individuals who are part of the Federal employee plan, or persons with disabilities or chronic conditions, will not be eliminated from coverage when they want to enroll.

Again, we see an effort to deal with the central questions that face health care reform in America, making sure that people are in a position to compare their plans so that there is real competition, and to make sure that nobody is left behind just because they are older or they suffer from a chronic condition.

So, in addition to these very positive features, in recent years, average Federal employee health plan premium increases have stayed below 3 percent per year per enrollee, while the Medicare Program has seen average annual increases of almost 9 percent during the same period.

So, Mr. President, what we are seeing is that well-structured competition, like in the system that Members of the Senate belong to, can work. It can work for patients and consumers in making sure they have good quality care. It can work for taxpayers in that it holds costs down, and it, for all practical purposes, is very similar to the system that we have in my hometown of Portland, OR.

In my hometown, Portland, we have the highest percentage of older people in the Nation now participating in managed care. It is about 60 percent. Certainly, while not perfect, it avoids much of the set of problems that we have seen in other parts of the country. You don't see the gag clauses, for example, in our plan. And, hopefully, the U.S. Senate will pass the legislation this session that Senators KYL, KENNEDY and myself have introduced to make sure that, as we go to the 21st century, all patients understand their options and all of them know about the various services that are available. But we don't have those gag clauses in Portland, and we do have high-quality managed care, and we are able to do it for substantially less than much of the rest of the Medicare system. The per capita rate in my hometown, the per person rate for Medicare participants, is still $60 to $80 below the national average for Medicare.

One of the things that I hope the Senate will do, on a bipartisan basis, is lift these penalties against towns like my home community that have done the heavy lifting and have ended up being penalized for it. I think, on a bipartisan basis, the U.S. Senate should make changes in Medicare to lift the reimbursement for low-cost counties, particularly in rural communities, and by doing so, benefit both seniors and taxpayers. Seniors will benefit from having the opportunity to get good-quality health plans in their areas, and it will also bring real choice and real competition for the first time to those areas. The fact of the matter is, many of those communities haven't been able to unleash entrepreneurial and competitive forces into their health systems such as we have in the private sector, because Medicare isn't paying those low-cost communities a fair rate. I have made changes in that discriminatory reimbursement proposal in my Medicare reform plan, and I hope the U.S. Senate will accept that in this session.

I was pleased to see that, in the last week or so, the head of the Health Care Financing Administration, Dr. Vladeck, has indicated that there is a significant backlog of needed changes required to bring Medicare up to date. I hope that we will see more discussion of that in the days ahead. I felt that it was positive news to see those comments from the head of the Health Care Financing Administration.

Mr. President, finally, let me say that I think, in addition to promoting competition, using the model of the Federal employee health plan, it's time for Medicare to look to the Federal employee health plan and the private sector for ways to improve quality in our health system. Again, there is nothing

partisan about the agenda to improve health care quality, but this is an area where Medicare has also lagged, both in relation to Federal employees and the private sector. In other parts of our health system, it's possible, for example, to get good statistics on disenrollment, people leaving because they are not satisfied with the plan. It is possible to get information about providers who leave a system because they, too, feel it doesn't adequately address the needs of patients in providing good-quality health care.

In other parts of the health system, there are grievance procedures, and we know, for example, how long it takes people to get through a grievance procedure, or how long it takes to get a referral, or what happens when you are denied benefits. In each of these areas so central to providing quality health care in America, Medicare is lagging behind the Federal employee health system, and Medicare is lagging behind much of the private sector. In my legislation, we would change that. We would require that these critical measures of quality be made available through report cards and other measures. I emphasize that today, Mr. President, because I think that, as we look to the 21st century of Medicare, we have an opportunity over the next few years to redesign the system and try to get it on track for the next century when we will have many more older people depending on Medicare.

So the alternative is very clear: A bipartisan effort to bring competition and choice and a new focus on quality in the Medicare Program, or to continue business as usual and face what the General Accounting Office has told us will be a program that has simply run out of money when we hit the next century. I believe that, after years of bickering and partisanship on this issue, there is an opportunity now to address Medicare reform in a bipartisan way. Democrats have been right in the Senate to call on making sure that benefits are defined, that older people have guaranteed, secure benefits. Republicans have been correct, in my view, in calling for more competition and more choice in the system. Today, I have tried to talk about how that competition and choice exists in the program that Members of the Senate belong to and is also available in much of the private sector.

Mr. President, this issue is so important that in the next century I believe that the public is going to ask every Member of the U.S. Senate, ''What were you doing to try to get Medicare on track?'' This program isn't just an important part of the Federal budget. It is going to be the Federal budget for the next 15 or 20 years. So now is the time to act to get the program on track. I believe that this can be done in a bipartisan way.

Mr. WYDEN. Mr. President, as I have said, I intend to come to the Senate floor each day this week part of an effort to help build bipartisan support in this body for Medicare reform.

Not via an independent commission. Not in the next Congress. But now, and by us, the Members of the 105th Congress.

I think we have an historic opportunity to transform Medicare from a 30-year-old, tin-Lizzie style social welfare program into a 21st century, comprehensive seniors health care system that is humane, cost-efficient and sustainable.

The reformed Medicare Program I envision, and which I think is within our grasp, is a health plan that is about choice, quality and access, and also about the efficiencies that characterize much of the Nation's private health care marketplace.

But changing Medicare will require tough decisions, tough votes and, as in turning a battleship in mid-ocean, a good deal of time and patience on the part of beneficiaries and health care providers.

We must start by making the right moves, the right changes, today, before some 75 million baby boom generation retirees begin swamping the Medicare Program in 2013.

In my private conversations with colleagues, I've been arguing that this is the classic pay-me-now, or pay-me-later situation. Structural changes enacted in the next year or two will not be easy. But in the face of what Congress would have to overcome beginning early in the next century, these changes will seem like child's play.

Medicare's problems are a snowball rolling down hill, picking up speed and mass on almost a daily basis. Now is the time to slow-down that snowball, if not stop it because in a few more years the program will be crushed by its weight.

Each year without structural reform makes the task that much harder, and the risk to balanced Federal budgets that much more significant.

And assigning the task to a bipartisan commission without first doing our best to solve Medicare's problems is a retreat not just from our responsibility, but from opportunity as well. I think there's a fervent desire among my colleagues to try to fix Medicare in the current Congress.

I think we gain little by assigning that job in the first instance to a bipartisan committee, only to have to try to make tough votes on their recommendations in 1998, an election year for those who need to be reminded.

The path to reform is not easy. Fortunately, however, there are sign posts and trail markers along the way, offering meaningful models for changes and reform.

I think we see these possibilities for a 21st century Medicare program in systems as diverse as the Federal Employee Health Benefits Program, which serves many Members of this body, to the Medicaid Program which now operates in my home state of Oregon under a special Federal waiver.

The Federal Employees Health Benefits Program offers its enrollees a portfolio of plans, each one with somewhat different services offerings. Consumers are helped to make appropriate, independent choices because the managers of FEHBP pay attention to the details, including the way plans develop written explanations presenting what individual policies will or won't do.

Further, those policies are then inspected and reviewed on performance, and FEHBP beneficiaries are then given what amounts to report card grades on many of the important care provisions so that average consumers can sit down at their kitchen tables and make plan-against-plan comparisons when they choose their coverage.

Finally, FEHBP smart-shopper managers negotiate high-quality service at competitive rates for enrollees. These government managers work with their plans on a continuous basis to upgrade the quality and range of services offered by the plans while keeping premium rates at lowest possible levels. At the same time, these managers work to diminish risk selection by the plans, so that older FEHBP members, or persons with disabilities or chronic conditions aren't eliminated from coverage when they want to enroll.

In recent years, average FEHBP plan premium increases have stayed below 3 percent per year, per enrollee, while the Medicare Program has ballooned to average annual increases of almost 9 percent during the same period.

Oregon's ground-breaking Medicaid plan also helps mark our way toward an improved national Medicare system.

In Oregon, we've expanded the traditional Medicaid Program to cover not only the federally qualified participants but also tens of thousands of working poor Oregonians who can't afford private insurance, but whose incomes would disqualify them for traditional Medicaid.

The result has been a tremendous reduction across the State in unreimbursed hospital charity care, more preventative medicine for youngsters and young mothers, and a per capita Medicaid cost rate that is 10 percent below the national average.

More care.

Less cost.

Efficient, preventative services that keep children and adults out of the hospital.

Managed care has played a dominant role in this success story, as it has in Oregon's Medicare experience.

Oregon's Medicare-qualified seniors have the highest penetration rate in the Nation in coordinated care. In Portland, nearly 60 percent of the Medicare beneficiaries are in managed care.

And in this, the State's highest reimbursed city for Medicare beneficiaries, the per capita rate is still 60 to 80 dollars below the national average for Medicare.

I suggest that we may be doing some things right, out West and in the FEHBP program. And sad to say, these good things we see happening in Medicaid and Medicare are almost in spite of

a Federal regulatory structure that hamstrings Medicare and Medicaid in terms of increasing both efficiency and quality, and expanding enrollment to the uninsured and under-insured.

This is a problem that is recognized even within the bowels of the Medicare management structure.

Mr. President, I was heartened to see the comments of my good friend Dr. Bruce Vladeck in the trade press last week. Specifically, Bruce acknowledged that there is a tremendous backlog of needed statutory changes required to bring Medicare up-to-date.

Gail Wilensky of Project Hope, puts it even more succinctly:

In sum, the present structure of Medicare hardly makes it surprising that it is facing financial problems. The elderly have limited options in the health care plans available to them. Medicare pays most of the costs for services it covers and almost all of the elderly have coverage that is supplemental to Medicare, either privately purchased Medigap or Medicaid.

That means there is little reason for an elderly person to seek out cost-effective physicians or hospitals, or to use lower cost durable medical equipment, laboratories or outpatient hospitals.

Dr. Wilensky goes on to say that there is little reason for practitioners to provide cost effective care ''if there is any medical gain to be had from providing services and some reason to fear legal repercussions if they do less than they might have done and the patient has an adverse outcome.'':

And because payments to capitated plans now follow payments for local fee-for-service Medicare, Medicare HMO's in many high-cost counties are extravagantly over-paid, while in low-pay counties plans and HMO enrollment languish because of under-reimbursement.

We throw money at fat health plans in big counties, while we starve the system of both choice and access—and I would argue quite probably quality as well—in counties where the payments are below the national average.

This current state-of-affairs is precisely antagonistic to our goal.

Let me postulate that it is nuts to reimburse Medicare HMO's in high-cost counties at the same level, more or less, of the highest-cost fee-for-service practitioners in those counties. That fact alone is one of the big reasons why, quite rightly, the administration has argued that we have a general HMO over-payment problem.

But the administration's argument that every HMO should be cut, however, to cure that problem is like saying amputation is an appropriate treatment for bunions.

Holy Dr. Kildare. In any other economic model or sector, a proposition like our current average adjusted per capita cost [AAPCC] formula would seem nuts. But that's the way it works in our creaking, inefficient and decidedly consumer unfriendly Medicare system.

Clearly, we must provide incentives for beneficiaries to choose just the cost-effective health care they need, and to demand that physicians, hospitals and other providers limit practice to cost-effective medicine.

This can be done while preserving the Medicare guarantee of a basic, good quality package of health services to every eligible senior, no matter what their health status or income level.

Here are components of a new Medicare system that provides both choice and quality, with cost efficiency:

First, radically reform the formula by which we determine how Medicare managed care programs are paid so that reimbursements are geared to the actual costs of managed care among elderly populations in a particular county, or region, rather than the local cost of fee-for-service medicine.

At the same time, scale-back payment increases in our high-reimbursement counties, and accelerate payments in the low-reimbursement counties where, because payments have been too thin, beneficiaries have only fee-for-service Medicare to choose from.

In other words, give millions of disenfranchised Medicare beneficiaries a real choice.

Second, require Medicare managers organize open bidding between plans in high-pay counties where profit margins are exorbitantly high.

Make the plans that are currently, hugely over-paid bid against one another, on price, for Medicare beneficiaries in those counties.

I believe such competitions should take place in every county where the average adjusted per capita cost—the AAPCC—is 120 percent of the national average.

In sum, make adjustments in the HMO payment formula that decrease reimbursements in counties that we know are substantially over-compensated; increase payments in counties that are so under-compensated as to discourage HMO entry and competition; and resist proposals to reduce all county payments, alike, from 95 percent to 90 percent of the local AAPCC rate—a crude tool that will hurt the cost-efficient counties much more than the ''fat'' counties.

Mr. President, I believe that accelerating the growth of good quality managed care, such as we have in Oregon, can be a major factor in curing Medicare's financial ills. Changing this AAPCC formula in a way that makes sense—in a fashion that does not kill our efforts to bring Medicare into vast areas of this country where no choice but fee-for-service medicine exists for beneficiaries—must be a high priority piece of the solution.

Third, put our two fastest growing portions of Medicare—home health care and skilled nursing facility care—on a financial management diet.

That regimen is called prospective payment, and it means that in much the same way we control hospital costs we would create a schedule of daily maximum service costs for different aspects of care in each of these important areas.

In my bill, S. 386, the Medicare Modernization and Patient Protection Act, prospective payment provisions for home health and skilled nursing facilities would, together, save approximately $20 billion over 5 years, according to the Congressional Budget Office.

Eventually, but quickly, I think we ought to impose these kinds of financial management tools on other aspects of fee-for-service Medicare.

I see no reason why, as a matter of global budgeting, that practitioners in this field ought not be held to the same kind of case management that HMO's require as part of their plans.

One method might be to require all Medicare fee-for-service practitioners to join a Medicare-sponsored provider network, which has at its core a case management system that ensures all participating beneficiaries get the care and quality they need, but that practitioners and other providers don't overbill or overprescribe.

This kind of PPO management would bring case gate-keeping into fee-for-service Medicare, ultimately producing reasonable price and cost controls in the system.

Fourth, require competitive bidding for durable medical equipment purchases and eliminate what Dr. Vladeck has termed the ''current silly inherent reasonableness'' process.

I know many of my colleagues may not have looked hard at this bit of Medicare arcana. But let me say that this is all about getting medical equipment paid for by the program at the lowest possible cost as determined by the market.

At the same time, we need to know more about what procedures and services work, and which don't, so that we can save money for the program and ensure that beneficiaries are getting optimum care.

The Health Care Financing Administration must be required to collect, analyze, and act on more of the available data, in this regard, and that admonition needs to be part of comprehensive Medicare reform.

Fifth, require HCFA to do local service-provider report cards for beneficiaries. This sort of qualitative analysis should extend both to HMO's and their practitioners, and to local fee-for-service doctors and other providers.

This needed reform would include authorizing the program to demand and collect all relevant data from Medicare participants.

Sixth, the program must move much more aggressively in establishing special plans and services for the sickest, frailest enrollees; these are the Medicare beneficiaries who are usually qualified for both health and income reasons to receive benefits from Medicaid as well.

These enrollees are the fastest growing group of Medicare beneficiaries, and the most expensive with costs to both programs amounting to about $100 billion per year.

Lack of systems to deal with the huge comprehensive care problems these folks face has resulted in the worst possible scenario; much money is wasted while many folks don't receive the type or quality of care they need.

Fortunately, there are a number of highly specialized programs called social HMO's or PACE programs, that provide coordinated care—using both Medicare and Medicaid bucks—for populations of these beneficiaries in less than two dozen communities. One of those programs, ElderCare at Providence Hospital in Portland, is up and running in my hometown, and it is serving these frail elderly at well below the national average cost for the so-called dual-eligibles.

Why don't we have more? HCFA currently requires each of these programs to apply on a waiver basis every time an individual community wants to start a social HMO or PACE program. This is expensive and time consuming, and it limits the reach of a very good, cost-effective system.

And again, something that takes about 5 minutes to start up in the private sector, takes about 5 years through the Federal Government.

For this group we must create greater access for highly specialized, dual-eligible programs by giving organizers clear and certain and uniform rules of entry through the Medicare Program; eliminate the so-called 50–50 rule, requiring 50 percent non-Medicare enrollment for any HMO serving Medicare beneficiaries, based on enhanced performance and quality standards; develop tougher restrictions on adverse risk selection making it harder for plans to deny enrollment to sicker, frailer beneficiaries; and set up a so-called outlier fund within Medicare, a special pool of cash fueled by reimbursement withholds from overpaid HMO's, to appropriately compensate plans that demonstrate they are serving sicker, more costly beneficiaries.

Seventh, reform our Medicare supplemental insurance laws—the Medigap regulations—to guarantee that every Medicare beneficiary can enroll in a Medigap program at any time. I believe this change is crucial to encouraging more seniors to try HMO's, knowing that if they decide they must return to fee-for-service medicine they will be able to get back into Medigap coverage.

About a dozen States, including my home State of Oregon, already require guaranteed-issue. The Medigap market has not been destroyed in those States. There must be a universal Federal standard protecting beneficiaries.

Eighth, ensure better treatment and more appropriate treatment for Medicare beneficiaries by capturing the service and efficiency offered by telecommunications technology.

An important aspect of this is expanding the terms and conditions under which Medicare will pay for services via the fiber-optic lifeline, and working with both the Federal Government and the States to knock down anticompetitive licensure practices and restrictions that hamper the ability of physicians and other practitioners to practice via this new technology.

I can tell my colleagues that Oregon, like much of the west, is looking hard at telemedicine as a way of getting better quality medicine to folks who live way out in the country; and there are lots of places falling under that definition, west of the Mississippi.

Medicare needs to help in that effort, not build walls against 21st-century medicine.

Ninth, Medicare must unleash the quality and efficiency promised by a rapidly growing cadre of alternative health care providers.

The program can save money and deliver to beneficiaries better, more targeted services by identifying and incorporating appropriate assignments for nurse practitioners, PA's, druggists, chiropractors, and other licensed professionals within the health care network.

Mr. President, these nine items are not the whole solution to modernizing Medicare. But I do believe that together, they represent an appropriate jumping off position for real Medicare reform that can be accomplished in this Congress.

I know colleagues from both sides of the aisle will be talking about their own ideas in the weeks and months to come. I urge them, I urge all of us, to move these issues through the congressional process beginning this year rather than expect a bipartisan commission to cure Medicare's problems for us.

Mr. President, tomorrow, I will go on to talk about other fundamental principles of Medicare reform.

I yield the floor.

Mr. CONRAD addressed the Chair.

The PRESIDING OFFICER. The Senator from North Dakota is recognized.

DISASTER SUPPLEMENTAL, THE BUDGET, AND THE CHEMICAL WEAPONS TREATY

Mr. CONRAD. Mr. President, my State has been hit by a massive disaster over this last weekend. North Dakota has been hit with the strongest storm in over 50 years. This is a storm of staggering proportions. Mr. President, North Dakota this last weekend got hit by a combination of an ice storm and blizzard that is unprecedented in the last 50 years.

In North Dakota, we are used to harsh winters, but, frankly, we have never seen anything quite like this one. This most recent storm not only involved ice, it involved 70-mile-an-hour winds. That combination has knocked down power poles all across the eastern part of our State. As of yesterday, we had 80,000 people still without power in the State of North Dakota, many of them with no power since Saturday morning. The temperatures have been 40 degrees below zero wind chill since the heat went out.

Mr. President, we have story after story of people who are huddled in homes around stoves trying to keep warm. My scheduling director, who is from the small town of Warsaw, ND, has talked to her mother, who is over 80 years old. She has had no heat since Saturday.

Mr. President, this is a disaster of truly staggering proportions. In this storm, there were whiteout conditions for 10 hours straight—10 hours straight—where the snow was so heavy and the wind so strong, you literally could not see 5 inches in front of your vehicle. As I have indicated, all of this led to, first of all, a massive snowfall. In some parts of our State, it was as much as 24 inches. In much of the State, it was 17 and 18 inches. That is on top of record snowfall that we had already received. This is a headline from before this most recent disaster: ''106 Inches of Snow and Rising.'' This is the Fargo Forum newspaper, the biggest newspaper in the State of North Dakota, and this was before the most recent disaster. Now we can put another 17 inches on top of that in the Fargo area. This was a record at 106 inches.

Mr. President, we have extreme hardship now across the State of North Dakota—no power, extremely cold temperatures, and facing us is the worst flooding in 150 years. The National Weather Service has now told us that we can anticipate the worst flooding in 150 years. That is on the heels of the most powerful winter storm in 50 years. It makes you wonder precisely what is happening with these weather patterns.

We have had an entire community ask to be moved to an emergency shelter—1,500 people. In one of the small towns in North Dakota, they asked to have the whole town put in an emergency shelter because there is no heat and has not been any heat since Saturday. We had a local rancher call in to the radio station, and he said, ''My entire herd is out because the fences went down with this incredible ice storm and these extraordinary winds.'' He asked people who were listening to the radio, ''If you see my herd roaming around, give me a call.'' I had another rancher call in from a town out in the western part of North Dakota, and he had a hundred cows and he had a calve crop coming in. Understand, this is the part of the season when you are calving. The calves are being born and being born in these disastrous conditions. They had a hundred cows, and they had a calve crop coming in, and they believe all of them are dead. They brought 10 into their own home—10 calves into their home to try to save them. All of them died. What was happening was, as the calves were being born, the wind is so strong, the snow is being forced up into their nostrils and the cows were suffocating. Now, if they didn't suffocate, they froze to death. Now, that is the extraordinarily brutal conditions that we are facing.